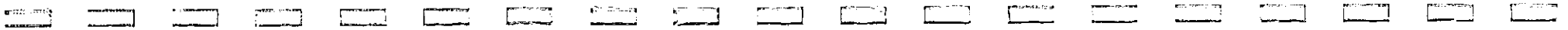
Fall 2010

Interim Report

Senate Memorial 33

Drug Policy Task Force

Report compiled on behalf of the SM 33 Drug Policy Task Force by the
RWJF Center for Health Policy at the University of New Mexico



UNM

Robert Wood Johnson Foundation | **Center for Health Policy** at the University of New Mexico

January 31, 2011

To: Chair, Interim Legislative Health and Human Services Committee
Chair, Interim Legislative Courts and Human Services Committee
Legislative Finance Committee
Legislative Council Service

Re: 49th Legislature, 2nd Session, 2010, Senate Memorial 33
Requesting the Robert Wood Johnson Foundation [RWJF Center for Health Policy at UNM] to create the Drug Policy Task Force to evaluate New Mexico's current approaches to drug policy through the use of law enforcement, treatment, prevention, and harm reduction and to develop strategies for effective change.

I am pleased to transmit the attached report. The SM 33 Drug Policy Task Force convened seven times from June to December 2010. This report contains specific recommendations, based on the four pillars concept, that are particularly applicable for the 2011 legislative session and consideration by the new administration.

The document is submitted as an interim report. Given the breadth of the topic and magnitude and detail of the tasks assigned in SM 33, the time did not permit the Task Force to complete its work. Accordingly, the Task Force is requesting that the time for completion be extended by one year. The RWJF Center for Health Policy is willing to continue in its role as convener.

Submitted by,

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EXECUTIVE SUMMARY

In 2010, Senate Memorial 33 created the Drug Policy Task Force to evaluate New Mexico's current approaches to drug policy through the use of law enforcement, treatment, prevention, and harm reduction and to develop strategies for effective change. The memorial recognizes the harm that alcohol and other drug use cause across the population, the devastated lives, the burdens on families and institutions, and the enormous costs to the public. It also acknowledges the impact of such use on the criminal justice and correctional systems and how these systems, in turn, sustain the problem of addictions.

After meeting seven times during 2010, the Task Force has accomplished a large part of its mandate and has focused the present Interim Report on policy recommendations that it felt should be addressed in the near term and are feasible under the present circumstances of fiscal constraint.

A core concept underlying most of the recommendations in this report is that the individual with an addiction—whether it is to alcohol, to an illicit drug, or the abuse of a prescribed drug—has a chronic disease that is treatable. To some extent, these conditions are potentially preventable. Dealing with addicted persons, whether at the level of community or during incarceration, requires application of this fundamental concept. Failure to do this means the problem is likely to continue its often ruinous course and allow the personal problems and social consequences to recur and recycle, often within the criminal justice system—all with continuing accumulation of social cost.

There are cultural barriers in New Mexico that impede effective application of this basic concept. One barrier is acceptance among many that alcohol abuse and other drug use are normative behaviors and that the risks, whatever they may be, are of insufficient importance to be considerations.

Another barrier is a pervasive view that society's response to criminal behavior associated with alcohol or with drug use should be punishment. The Task Force believes that, whether or not punishment is part of the consequence, it is in society's greater interest that all such persons should have access to treatment.

Another barrier in our state is the lack of capacity in terms of human resources, programs, and facilities to manage persons with addiction—we have perhaps as little as 50% of what is needed statewide. This is a long-term issue, and it won't be fixed by anything that can be done quickly and without cost. Planning to address this must begin now.

A second core concept is the extraordinary cost-benefit of treatment. In 2009, the Substance Abuse and Mental Health Services Administration reported on an analysis that demonstrated that, on the average, each dollar invested in treating drug addiction yields a savings to the public of seven dollars. The funding of no other

major sector in health care returns savings that come close to this extraordinary rate. Treating addictions can be expensive. Not treating addictions is vastly more expensive.

A third core concept is the ongoing need for effective primary prevention. Primary prevention means taking steps that reduce the number of persons who begin to engage in harmful use of alcohol, particularly underage drinking, in use of illicit drugs, and in abuse of prescription drugs. Fewer persons involved in these activities means lower numbers of persons who become sick, who engage in behaviors that are criminal, or who do harm to others; a lessening of the burdens on the criminal justice and corrections systems; and a reduction of costs. Primary prevention is a shared responsibility of the public health sector, health care providers, educators, families, and communities.

This Interim Report provides the initial recommendations that the Task Force believes should be addressed immediately. Most of these fall under the categories of the four pillars approach (prevention, harm reduction, treatment, and enforcement). The principal recommendations are listed and briefly summarized here.

Synopses of Task Force recommendations (with page numbers from the body of this Interim Report):

1. Need for Better Coordination of Community Services.
The Behavioral Health Services Division and others need to better engage local communities in the planning and coordination of programs that affect them. (Page 19)

2. Primary Prevention: Underage Drinking and Alcohol Abuse.
The legislature and the governor should increase state alcohol tax and tax by local option, as this is a proven strategy to reduce underage drinking, alcohol abuse including binge drinking, and addiction. (Page 20)

3. Primary Prevention: Use of Illicit Drugs and Prescription Drugs.
The Behavioral Health Services Division should sustain and preferably expand the evidence-based community-level approaches already in use. This approach has been shown to reduce arrests related to drug use. (Page 24)

4. Harm Reduction: Syringe Exchange Programs (SEPs) and Overdose Prevention.
The Department of Health should open the SEPs to teenaged injection drug users.

The Department of Health should simplify the training requirements for being an instructor for the administration of Narcan and should advocate as a standard of care that patients who receive opiate prescriptions also receive a prescription for Narcan and instructions for how to use it. (Page 26)

5. Treatment: Inventory of Behavioral Health Treatment Capacity.
The Behavioral Health Services Division should take the lead in creating a comprehensive, statewide, centralized inventory of behavioral health assessment and treatment providers and facilities. (Page 28)

6. Treatment: Integration of Behavioral Health Services and Primary Care.
The Behavioral Health Collaborative should build connections between the Core Service Agencies and primary care, particularly the health care homes that will be emerging with health care reform. This should include funding for services provided through primary care. (Page 29)

7. Treatment: Medication Assisted Treatment (MAT): Suboxone and Methadone.
The Behavioral Health Services Division, the Medical Assistance Division, and others should prioritize and take action to make opioid replacement treatment with Suboxone and methadone widely available for opiate addicted persons. (Page 31)

8. Enforcement: Legislation Regarding Sentencing and Collateral Consequences.
The Sentencing Commission should support legislation that (a) improves opportunities for diversion instead of incarceration and (b) reduces lifelong barriers to later social integration for those who have gone through the criminal justice system. (Page 36)

9. Enforcement/Treatment: Management of Prison Addiction Services.
The Corrections Department needs to ensure and document that prisoners with histories of addiction are offered and actually receive treatment services at a standard of care, including ensuring that there is an effective handoff at time of release. (Page 39)

10. Treatment: Peer Addiction Services.
The Corrections Department, county detention facilities, and their community partners should improve and facilitate access of prisoners and of persons being released to peer addiction counselors. (Page 43)

11. Enforcement/Treatment: County Jails.
The legislature needs to support counties in helping improve the capability of county jails to manage the large numbers of inmates with addictions and other behavioral health problems. The first step is backing for a survey to understand the scope of the problem. (Page 44)

(End of Executive Summary)

SM 33 DRUG POLICY TASK FORCE BACKGROUND AND HISTORY

Senate Memorial 33 of the 49th Legislature, 2nd Session, 2010 was introduced by Senators Bernadette M. Sanchez, Pete Campos, Linda M. Lopez, David Ulibarri, and Peter Wirth, "Requesting the Robert Wood Johnson Foundation [Center for Health Policy at the University of New Mexico] to create the Drug Policy Task Force to evaluate New Mexico's current approaches to drug policy through the use of law enforcement, treatment, prevention, and harm reduction and to develop strategies for effective change." The full wording of SM 33 is attached in Appendix A.

Secretaries and directors within the designated agencies were invited in writing to name a representative to serve on the Task Force. Other persons as specified in the memorial were identified, and still others stepped forward to participate, and if attending more than once they were designated either as members, advisors, or, in the case of students and interns, assistants. A roster of participants is in Appendix B.

There were seven meetings in the interval from June to December 2010 (Appendix C). Meetings included review of other related reports to the legislature and governor, presentations of background material, and review of data pertinent to national trends and to New Mexico. Recommendations were determined by consensus of persons participating in discussions and with distribution of minutes and draft reports.

The Task Force used the four pillar categories (prevention, harm reduction, treatment, and enforcement) to organize its policy strategies and develop recommendations. Its recommendations span personal health care, public health, and policy.

The focus of the Task Force's attention has been more on substance user (whether alcohol or addictive substance) rather than on the specifics of particular drugs. The report deals with the person, whether facing detention or incarcerated or released. Prevention, assessment and treatment are stressed with emphases on current limits of behavioral health care infrastructure and access. The contexts are the community and the criminal justice and corrections systems, with emphasis on best practices and policies.

In framing the issues, the Task Force has taken into account New Mexico's budgetary shortfall in FY 2011 and the severe budgetary constraints being faced for FY 2012 and beyond.

Because of the breadth of the subject matter, and having to function with only donated staff support, the Task Force realized it would take longer than the prescribed time to complete the assignments in the memorial. The Task Force therefore elected to prioritize subject matter and recommendations that might reasonably be addressed in the legislative session convening in January 2011 and

that might be useful considerations for the incoming administration and new cabinet.

Accordingly, the Task Force's priorities have focused largely on policies that will not require substantial new funding and on planning needed to address matters where current practices are inefficient or result in costs that ultimately can be reduced.

Without having completed its full mandate, and with the need to engage the new administration, the Drug Policy Task Force is requesting that it be extended for another year.

STARTING POINTS

Substance Abuse: Alcohol and Illicit and Prescription Drugs*

New Mexicans continue to surpass national rates for the negative consequences of excessive consumption of alcohol and use of both illicit and prescription drugs.

For more than 15 years, New Mexico's death rate for alcohol-related chronic diseases (e.g., chronic liver disease and cirrhosis, alcohol dependence, etc.) has been first or second in the nation, with rates 1.5 to 2 times the national rate. In addition, over the last 15 years, New Mexico's death rate for alcohol-related injuries (motor vehicle crashes, drowning, suicide, homicide, etc.) has also consistently been among the worst in the nation, ranging from 1.4 to 1.8 times the national rate.

New Mexico also suffers from a high burden of both illicit and prescription drug overdose. There has been a rise in prescription drug overdose both nationally and in New Mexico. In 2008, the most common drug types causing overdose death in the state were prescription opioid painkillers (e.g., methadone, oxycodone, hydrocodone), heroin, tranquilizers and muscle relaxants (e.g., benzodiazapines), cocaine, and antidepressants. The overdose death rate from a combination of illicit and prescription drugs increased 150% in the past five years. Prevention of drug abuse among adolescents is key to stemming this trend.

*From New Mexico Department of Health. *The State of Health in New Mexico.* 2011.

The consequences of drug and alcohol use disorders are severe in New Mexico. They comprise the state's third leading cause of death overall and first leading cause among youth and young adults. New Mexico consistently ranks among the worst in the nation for death from drugs and alcohol. The devastation caused by substance abuse is also associated with domestic violence, crime, poverty, motor vehicle crashes, chronic liver disease, infectious diseases, mental illness, and other medical problems.[1]

Drug and alcohol use disorders are primary forces driving incarceration and recidivism in New Mexico. An estimated 85-90% of New Mexico state inmates have substance use disorders.

The National Institute on Drug Abuse (NIDA) categorizes criminal offenses related to substance use as follows:

> Substance use is implicated in at least three types of drug-related offenses: (1) offenses defined by drug possession or sales, (2) offenses directly related to drug abuse (e.g., stealing to get money for drugs), and (3) offenses related to a lifestyle that predisposes the drug abuser to engage in illegal activity, for example, through association with other offenders or with illicit markets. Individuals who use illicit drugs are more likely to commit crimes, and it is

[1] Adapted from New Mexico Department of Health. *The State of Health in New Mexico,* 2011.

common for many offenses, including violent crimes, to be committed by individuals who had used drugs or alcohol prior to committing the crime, or who were using at the time of the offense.[2]

[2] National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide.* NIH Publication No. 06-5316, July 2006.

OVERARCHING ISSUES

Addiction is a treatable chronic brain disease that affects behavior.[3]
It is necessary to recognize and manage addictions to alcohol and other drugs as chronic diseases. Framing the addiction in this way is essential in order to successfully address the human tragedies associated with these addictions and the related costs of health care, of crime and associated judicial actions and incarcerations, and of other direct and indirect consequences. (For evidence-based principles of treatment of drug abuse from the National Institute on Drug Abuse, see Appendix D.)

A basic premise underlying many of the recommendations in this report is the primacy of dealing with persons involved in alcohol- and drug-related crimes from the perspective of their having a chronic disease. To neglect this fundamental issue is to perpetuate the cycle of addiction and crime and all that goes with it.

Benefit-cost ratio of addiction intervention is 7:1.
Seven dollars are saved for each dollar of intervention spent.[4] Thus, while there will be costs to such interventions, the costs of not intervening are far greater. Interventions in this area are one of the most rational, beneficial, cost-saving actions in all of health care.

Within New Mexico, the numbers and distribution of providers to provide services for persons with behavioral health needs, including addictions, is insufficient in New Mexico communities and in the prison system.
The extent of deficit to reach just basic services in the state is not clear, but to estimate current human resource capacity accessible for behavioral health services to be at 50% would not be an irresponsible assumption. The deficiencies in rural communities are of particular concern.

Medication Assisted Treatment (MAT) is grossly underutilized in New Mexico communities and in the prison system.
Opioid replacement therapy is a proven and cost-effective method of addiction treatment. Steps to address the barriers that contribute to the limited deployment of MAT are covered in the recommendations of this report.

Fragmentation of state programs continues to frustrate local planners.
While the coordination of behavioral health services is the goal and responsibility of the Behavioral Health Collaborative and the Local Collaboratives, programs still reach the community level via separate agencies. Fragmentation creates confusion

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[3] National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide.* NIH Publication No. 06-5316, July 2006.

[4] Miller T, Hendrie D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis.* DHHS Publication No. 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

and diminishes effectiveness. The differences vary across regions of the state, require local and regional specificity, and demand meaningful community involvement.

Persons with addictions who have been incarcerated account for a major portion of the costs and social consequences of alcohol and other drug use.
The New Mexico Department of Corrections (2002) reported that 85% of prisoners have some kind of problem with drugs or alcohol. Ninety-five percent of people incarcerated in New Mexico will return to their home communities. If the addictions and other health issues are not addressed, persons will take these issues back to their communities. This shifts and increases the fiscal and resource burdens on an already overwhelmed system of health and social services.

While assuring public safety is always an issue, diversion into treatment can be a preferred strategy as an alternative for persons with addictions who have been arrested and whose criminal activities do not include violence.
Options for immediate diversion into treatment at the time of arraignment have the potential of bypassing the costs and avoiding the negative branding bestowed by going through the criminal justice process. Drug courts have been helpful, but take time to enter and tend to accept offenders who are not likely to be heading to prison anyway. Additionally, early parole for low-level drug offenders should be a considered. Evidence supports these approaches for people who do not have an extensive history of involvement with the adult criminal justice system.

Collateral consequences of sentencing and incarceration.
Various legal regulations and statutes, both federal and state, create lifetime "collateral consequences," particularly for people who are seeking legal citizenship status. Some felony convictions restrict access to housing, educational opportunities, and employment. These can profoundly impact the ability for released prisoners and even diverted offenders to reintegrate, and they increase the likelihood of a return to substance use and crimes.

Treatment programs and therapeutic communities in prisons, when done properly along with release planning, active parole programming, and aftercare, can be effective in reducing alcohol and drug use, arrests, recidivism, and costs.[5]
Being in prison with untreated or undertreated addictions greatly reduces the likelihood of successful reintegration in society after release and greatly increases the likelihood of recidivism. Approximately half of prisoners with untreated addictions will return to incarceration within two years. With treatment this

[5] Welsh WN. *Evaluation of Prison Based Drug Treatment in Pennsylvania: A Research Collaboration Between the Pennsylvania Department of Corrections and the Center for Public Policy at Temple University:. Final Report*, 2002. http://www.ncjrs.gov/pdffiles1/nij/grants/197058.pdf. Accessed December 14, 2010.

number should decrease to about 35%. This would constitute significant savings in New Mexico with the average annual cost per inmate at $41,000.

Managing the addictions and working with released prisoners during parole in order to optimize the prospects for reintegration have been associated with reduced recidivism and reduced overall numbers of prisoners.[6]

Recent surveys indicate the public may be out in front of conventional political wisdom. A national survey of attitudes on crime and punishment sponsored by the Pew Center on the States indicated public support for addiction treatment and rehabilitation of nonviolent offenders. Ninety-one percent of respondents agreed with the statement "What really matters is that the system does a better job of making sure that when an offender does get out, he is less likely to commit another crime."[7]

Special populations need special attention.

Youth:

The prevalences of alcohol and other drug use self-reported by middle and high school students in New Mexico are among the highest in the U.S. Youth who use drugs are far more likely to have problems as adults with drug addiction. While there has been some reduction of alcohol use in recent years, illicit drug use has been climbing.[8] The heroin death rate among youth has risen sharply.[9], The prevention of alcohol and other drug use in children is an essential component of addiction prevention. Accordingly, the Drug Policy Task Force is making primary prevention a major element in its recommendations.

Women and girls:

> Up to 92% of incarcerated girls have experienced one or more forms of physical, sexual, and emotional abuse before entering the juvenile justice system. More than 45% have been beaten or burned at least once; 40% have been raped; 32% have current or past sexually transmitted diseases; and 32% have chronic health problems. Girls exposed to violence on an ongoing basis are prone to self-abusive behavior, depression, mental illness, drug use, and suicide.

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[6] States help ex-inmates find jobs. New York Times, January 25, 2011. http://www.nytimes.com/2011/01/25/business/25offender.html?pagewanted=1&emc=eta1. Accessed January 25, 2011.

[7] Pew Center on the States. *Public Attitudes on Crime and Punishment*, September 2010. http://www.pewcenteronthestates.org/uploadedFiles/wwwpewcenteronthestatesorg/Initiatives/PSPP/PSPP_National%20Research_web.pdf?n=6608. Accessed January 6, 2011.

[8] Green D. Highlights from the 2009 New Mexico High School Youth Risk and Resiliency Survey, *New Mexico Epidemiology* 2010; 2010 (7) Available at http://nmhealth.org/ERD/HealthData/yrrs.shtml

[9] Shah NG, Lathrop SL, Reichard RR, Landen MG. Unintentional drug overdose death trends in New Mexico, USA, 1990-2005: combinations of heroin, cocaine, prescription opioids and alcohol. *Addiction*. 2008;103(1):126-36.

Despite ample data that men and women substance abusers differ, substance abuse treatment has traditionally been developed with male substance users in mind. Prison programs developed for men have historically been imposed on women, and the women were then blamed when the programs were ineffective. Only recently have programs begun to offer gender-sensitive and gender-specific treatment for women. These treatment programs have been shown to be more effective for women than traditional treatment programs.

Increasingly, the services provided to women in New Mexico Corrections Department are reflecting differences in the experiences and needs of women prisoners, but much more work is required. Though there are guidelines available to assist states in the development of gender treatment standards, New Mexico has yet to develop or implement standards for gender-sensitive treatment.

Additionally, a large number of children born in New Mexico to substance using women are referred to the Children, Youth, and Families Department (CYFD) without other evidence of potential for child abuse or neglect. New Mexico law does not define substance use in pregnancy as child abuse nor does federal law require reporting of all substance-exposed infants. Not only do these unnecessary referrals increase the workload of already-burdened CYFD caseworkers, they create great fear among substance using pregnant women that is a major deterrent to seeking prenatal care.

The SM19 Taskforce developed a comprehensive state plan for improving policies and systems relating to substance abuse in pregnancy. Specifically, the plan calls for reducing unnecessary referrals to CYFD and increasing home visitation; increasing access to quality substance abuse treatment, prenatal care and family planning for women; increasing access to supportive services; increasing treatment over incarceration for non-violent drug-related crimes; changing attitudes about substance use; increasing research and data collection.[10]

Issues that require particular attention include the following:

- Develop and implement gender-sensitive treatment standards and rules for New Mexico.
- Develop a New Mexico state–owned centralized referral system for women seeking substance abuse treatment in New Mexico.
- Increase access to case management for substance abusing women and their families by requiring assessment of case management needs and referral to core service agencies.
- Create alternatives to incarceration for drug offenses and more gender-sensitive probation and parole policies for pregnant women and women with young children.

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[10] New Mexico Governor's Women's Health Office. *Assess and Improve Access to Substance Abuse Treatment and Prenatal Care for Pregnant Women with Substance Abuse Problems: Final Report,* November 2010.

- Refer substance-exposed infants to home visitation programs rather than to child protection.
- In hospitals, enact and enforce treatment standards that encourage substance abusing women who are pregnant to get prenatal and post natal care.
- Enact legislation requiring all substance abuse facilities to screen patients for family planning services and provide such services or make appropriate referrals.
- Enact legislation requiring all publicly funded addiction services that provide treatment for women to provide services to women who are pregnant.
- Encourage the use of MAT for all women, including pregnant women, unless not medically advised.

Persons over 50:

Older adults face a rising problem of alcohol abuse, pharmaceutical drug misuse and abuse, and illicit drug use.[11], [12] The Substance Abuse and Mental Health Services Administration projects a doubling of the numbers with alcohol and other substance use (notably prescription drug abuse problems) in persons over age 50 by the year 2020.

More older people are hospitalized for alcohol-related problems—for example, falls with injury, medication mismanagement, as well as for alcohol-related diseases—than for heart disease.

Alcohol, prescription drug misuse (or abuse), and other substance abuse may go on longer in older persons without intervention.

A large majority of older persons prefer to receive management of behavioral health issues from primary care providers than from a behavioral health specialist. Integrating behavioral health treatment with primary medical care has been shown to be extremely effective for older adults. This is only being tried in a limited way in New Mexico.

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[11] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *The DAWN Report: Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults.* Rockville, MD. November 25, 2010.

[12] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *The DAWN Report: Emergency Department Visits Involving Illicit Drug Use by Older Adults: 2008.* Rockville, MD. September 9, 2010.

RECOMMENDATIONS OF THE DRUG POLICY TASK FORCE

COORDINATION OF COMMUNITY SERVICES PROVIDED BY MULTIPLE STATE AGENCIES

There are at least 40 agencies in New Mexico involved in drug policy. Addressing fragmentation and barriers to coordination falls to the Behavioral Health Collaborative and the Local Collaboratives. Community-based members of the Drug Policy Task Force report that behavioral health services still reach the community level via separate agencies, with the fragmentation creating confusion and diminished effectiveness. The differences across various regions of the state require local and regional specificity and demand meaningful community involvement.

The Task Force supports the importance of the role of the Local Collaboratives as essential for focusing and promoting coordination of services at the local level. Also the Task Force appreciates the development of the Core Services Agencies (CSA) and hopes the CSAs will work not only with the behavioral health providers but with other provider sources such as primary care as well. The CSAs should broaden rather than restrict the delivery of needed behavioral health services.

The New Mexico prison system including Probation and Parole within the Corrections Department and the counties' management of persons released from jails must be included in the coordination efforts.

Recommendation for the Human Services Department, the Behavioral Health Planning Council, Department of Health, Corrections Department, and counties:

Facilitate and promote the shift of the conceptual axis of service from agency-specific programs to community or client-responsive solutions. Engagement of community leadership by the Local Collaboratives early in the planning process would be helpful.

PRIMARY PREVENTION OF ALCOHOL USE

Findings:

Approximately 5% of the U.S. population drinks heavily, and 15% of the population engages in binge drinking (CDC).[13]

While the U.S. rate of alcohol-related chronic disease death rate declined 15% from 1990 through 2007, New Mexico's rate remained stable and high. As a result, New Mexico's rate went from being 1.6 times the US to being almost twice the U.S. rate in the early 2000s.

In New Mexico, an estimated 124,000 persons need treatment for alcohol use.[14]

The economic outlay in New Mexico for alcohol-attributable health, injury, lost productivity, and other social costs has been estimated at $2.8 billion (2007), or more than $1,400 for every person in the state. This represents an 11% increase over the prior year and is associated with an 11% increase in deaths from alcohol use.[15]

Economic Costs of Alcohol Abuse, New Mexico, 2007

Cost Component	Costs ($ in millions)	Percent of costs
Health Care Costs		
Alcohol-related prevention and treatment services	$83	3%
Medical consequences of alcohol consumption	$379	14%
subtotal	$462	17%
Productivity Costs (Alcohol-Related Lost Earnings)		
Lost future earnings due to premature deaths	$559	20%
Lost earnings due to illness	$1,342	48%
Lost earnings due to crime (incarcerations and victimization)	$118	4%
subtotal	$2,019	72%
Other Social Costs		
Crimes—criminal justice and property damage	$84	3%
Social welfare program administration	$8	0%
Motor vehicle crashes—property damage	$220	8%
Fires—property damage	$11	0%
subtotal	$323	11%
Total Costs	$2,804	100%

[13] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *National Survey on Drug Use and Health*, 2004 and 2005.
[14] ibid.
[15] New Mexico Department of Health. *The Economic Cost of Alcohol Abuse in New Mexico: 2007*, 2011. https://gogw1.health.unm.edu/gw/webacc?action=Item.Read&User.context=93bc478511b7d9176d2e9e53f8fc1fa6537bdbf&Item.drn=242380z9z3&merge=msgitem&Item.index=8.

These costs, which are absorbed by the public and state-funded programs, dwarf the annual revenues obtained from the excise tax on alcohol ($39 million).

Alcohol abuse is a central issue in terms of the burdens and problems it creates in connection with all phases of criminal behavior. A general primary prevention approach to reducing excessive drinking (particularly binge drinking) would have an impact on alcohol-related crime levels.

The priority for prevention must be the younger age groups. New Mexico leads the country in numbers of children who start drinking before age 13, and in the prevalence of students who drink regularly and who are binge drinkers.

Survey of NM Students, Grades 9–12 (2009)[16]

Current drinker	40.5%	80% of drinking occurs at home.
Binge drinkers	25.0%	Almost 2/3 of current drinkers are binge drinkers. Binge drinking accounts for 90% of alcohol consumption in 12- to 18-year-olds.
First drinking before age 13	29.4%	NM leads the nation in percent of kids who start to drink before age of 13.

Persons who initiate drinking before age 21 are much more likely to abuse or become dependent on alcohol as adults than persons who initiate after age Persons initiating before age 14 are more than six times as likely to become dependent.[17]

In developing strategies for prevention, particular attention must be paid to restricting access for younger populations. Two approaches are effective: (1) environmental strategies and (2) direct prevention services. Current budgetary restraints suggest a focus on environmental strategies, which are clearly cost-effective. The Task Force strongly supports evidence-based primary prevention of initiation and early use of alcohol and other substances.

The CDC's Task Force on Community Preventive Services makes recommendations for public policies based on rigorous systematic reviews of the research literature concerning effectiveness and outcomes. With respect to problems related to alcohol use, the Task Force has developed "environmental" recommendations in the following areas. These have been demonstrated effective:[18]

- Maintain dram shop liability.

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[16]New Mexico Department of Health. *Youth Risk and Resiliency Survey: 2009 High School Alcohol Report*, 2010. http://www.youthrisk.org/pdf/2009/YRRS-2009-Presentation.pdf.

[17] *2009 National Survey on Drug Use and Health: Detailed Tables*, 2010. Available at http://oas.samhsa.gov/WebOnly.htm#NSDUHtabs.

[18] Guide to Community Preventive Services. Preventing excessive alcohol consumption. www.thecommunityguide.org/alcohol/index.html.

- Increase alcohol taxes.
- Maintain limits on hours of sale.
- Regulate alcohol outlet density.
- Enhance enforcement of laws prohibiting sales to minors.

Additionally, the high proportion of drinking done at home by youth points to the importance of strategies targeting social liability of property owners.[19]

The Institute of Medicine includes raising excise taxes among its recommended approaches to reducing underage drinking.[20]

Because of its simplicity and economy, and particularly because research demonstrates it works to reduce alcohol consumption and because it will raise revenue, the Drug Policy Task Force's principal recommendation is for an alcohol excise tax increase. A bill analysis by the Taxation and Revenue Department in 2010 projected that a statewide increment of 5 cents per alcoholic drink (all types) excise tax would generate in excess of $40 million per year, or around $80 million for a 10 cent increase.

A survey by Research & Polling Inc. indicated that 69% of voters favored an increase in alcohol excise tax if the funds could be used for alcohol treatment or prevention programs.[21]

Opportunities to advance evidenced-based environmental interventions in the other areas listed above should be developed.

For persons with alcohol use disorders, treatment can be effective, even lifesaving, and is indicated. Other sections of this report deal with the long-term need for broadening the behavioral health care infrastructure (see page 29). Near term opportunities exist for public funding of behavioral health care in primary care settings. The report describes the importance and usefulness of screening, brief intervention, and referral for treatment (SBIRT). Medicaid could help by enabling the use of Medicaid billing codes for SBIRT services. The UNM Health Sciences Center could assist by promoting SBIRT training for health professionals and taking steps to identify and recommend best practices for implementing SBIRT.

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[19] Imm P, Chinman M, Wandersman A, Rosenbloom D, Guckenburg S, Leis R. *Preventing Underage Drinking: Using Getting To Outcomes™ with the SAMHSA Strategic Prevention Framework to Achieve Results.* Santa Monica, CA: RAND Corporation, 2007.
http://www.rand.org/pubs/technical_reports/TR403.

[20] National Research Council and Institute of Medicine. *Reducing Underage Drinking: A Collective Responsibility, A Report Brief,* September 2003.
http://www.iom.edu/~/media/Files/Report%20Files/2003/Reducing-Underage-Drinking-A-Collective-Responsibility/ReducingUnderageDrinking.pdf.

[21] Tax Payer Relief, a webpage posted by New Mexico Common Cause.
http://www.alcoholtaxincrease.org/taxpayerburden.htm.

Recommendation for Legislature and Medical Assistance Division:

1. Implement an alcohol excise tax increase either—or preferably both—as a state and local option.
   - A state alcohol tax has the advantage of impacting the greater numbers of persons.
   - A local option has the advantageous option of targeting the revenues toward alcohol and other drug prevention programs, as has been demonstrated successfully in McKinley County.

2. Enable the use of Medicaid billing codes for SBIRT services.

PRIMARY PREVENTION OF USE OF ILLICIT DRUGS AND MISUSE OF PRESCRIPTION DRUGS

Findings:

An estimated 45,000 New Mexicans need treatment for illicit drug use.[22]

Data from 2009 YRRS of New Mexico Students, Grades 9–12, Drugs Used in Preceding 30 Days[23]

	Percent
Marijuana	28.0
Painkillers (to get high)	14.3
Inhalants	7.7
Cocaine	5.6
Methamphetamine	3.9
Heroin	3.2

Abuse of prescription drugs in the US has skyrocketed in recent years. Emergency department visits involving nonmedical use of prescriptions drugs doubled from 2004-2008.[24]

> With respect to nonmedical use of prescription drugs, it is evident that "recent public health and law enforcement measures intended to prevent nonmedical use of such drugs have not prevented rate increases, and additional measures are needed urgently."[25]

In New Mexico, unintentional poisoning death rates from prescription drugs doubled in the period from 2002-2008, overtaking the death rate from illicit drugs.[25]

New Mexico is one of several states that has a Prescription Drug Monitoring Program (PMP), an electronic registry of prescriptions filled for controlled substances. Prescribers and pharmacists should be encouraged to access this program to learn of the differed controlled substance prescribed to a patient by other providers in order to inform the course of treatment. The PMP can also flag unusual patterns related to the use of controlled substances such as number of pharmacies visited and number of prescriptions filled per patient. Full use of PMP 's potential will require information technology that is

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[22] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *National Survey on Drug Use and Health*, 2004 and 2005.

[23] New Mexico Department of Health. *Youth Risk and Resiliency Survey: 2009 High School Alcohol Report*, 2010. http://www.youthrisk.org/pdf/2009/YRRS-2009-Presentation.pdf.

[24] Centers for Disease Control and Prevention. Emergency department visits involving nonmedical use of selected prescription drugs—United States, 2004-2008. *MMWR* 2010;59(23):705-07.

[25] Shah N. Prescription drug overdose. *New Mexico Health Perspective* 2010;2010(1):1-2. A health policy brief from the New Mexico Department of Health.

not currently in widespread use. It is an incomplete solution. Only some persons abusing prescription drugs obtain them from via prescriptions. Others obtain them from households and illicit distribution sources. It is a start.

Recommendations for the Human Services Department, the Department of Health, and the Board of Pharmacy:

1. Support current evidence-based preventive approaches to reduce use of illicit drugs at the community level and extend them to higher education campuses. These build on the Institute of Medicine framework and the strategic prevention framework developed by SAMHSA, and they have demonstrated effectiveness, for example, in reducing arrests.

2. Encourage prescribers and pharmacists to continue to develop and proactively use the New Mexico Prescription Drug Monitoring Program.

HARM REDUCTION: SYRINGE AND NEEDLE EXCHANGE AND OVERDOSE PREVENTION

Findings:

Syringe exchange programs (SEPs) are associated with reduced incidence of HIV among intravenous drug users and are cost-effective in settings where prevalent HIV is transmitted by intravenous drug use.[26], [27] Intravenous drug use is the most common source of new hepatitis C infections. SEPs are a mainstay for prevention strategies against hepatitis C and other infections and complications arising from needle sharing. SEPs generate referrals to drug treatment programs. An important restriction is the present exclusion of teens from participation in SEPs.

In terms of overdose prevention, administration of the opioid antagonist naloxone (Narcan) is lifesaving, whether the overdose is due to an opiate narcotic such as heroin or to a prescription opiate that is being misused or abused.[28]

Narcan can be given nasally, and this should be done on-site as emergency first aid, for example, by a family member or friend. Dissemination of training in the use of Narcan to the public is limited in part by the requirement that persons teaching the simple intervention are required first to complete a two-day course of training. This appears excessive. Persons experienced in this area have recommended that the teaching of trainers can be safely completed in less than an hour.

Recommendations for the Department of Health:

1. Maintain and, where possible, expand syringe and needle exchange programs, including outreach and referrals to drug treatment services, in settings where drug use and needle sharing are prevalent.

2. Develop policies and procedures to address the needs of intravenous drug users below the age of 18.

3. Hold harmless from any budget cuts cost-effective harm reduction programs, such as Narcan distribution for overdose prevention.

4. Increase the number of persons trained in the nasal administration of Narcan by
   (a) Reducing the training requirements for teaching this technique, and

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[26] Hall HI, Song R, Rhodes P, et al. HIV Incidence Surveillance Group. Estimation of HIV incidence in the United States. *JAMA* 2008;300:520-529.

[27] Belani HK, Muennig PA. Cost-effectiveness of needle and syringe exchange for prevention of HIV in New York City. *J HIV AIDS Soc Serv* 2008;7:229-240.

[28] Shah, N. *Current Efforts and Ideas to Reduce Drug Overdose Included in New Mexico in Report to Interim LHHS on House Memorial 9: Medication Assisted Treatment for Opiate Addiction*, November 4, 2009.

(b) Recommending as a standard of care that patients who receive recurrent opiate prescriptions also receive a prescription for nasal Narcan and instructions for how to use it.

INVENTORY AND MAPPING: BEHAVIORAL HEALTH ASSESSMENT AND TREATMENT CAPACITY

Findings:

The extent of the present deficit of services related to behavioral health assessment and treatment is not clear, but to place the numbers at 50% of need would not be an irresponsible assumption. Addressing this deficit represents a long-term issue, but one for which planning is urgent.

There is at present no centralized census of behavioral health assessment and treatment providers and facilities. Information is scattered across multiple agencies, and its availability is fragmented and inefficiently available to planners and the public.

Recommendation for Behavioral Health Services Division, Purchasing Collaborative and State Entity, CYFD, ALTSD, Sentencing Commission, and Association of Counties:

The Behavioral Health Services Division should take the lead to generate, maintain, and make available an integrated inventory of behavioral health assessment and treatment resources, including mapping/locations and specific services. The format should be easy to use for individuals seeking such information. The inventory should incorporate available agency-specific inventories and listings and tribal and federal services. It should include MAT services at local public health offices and elsewhere, site-specific information on available services, populations served, eligibility, payment options and funding sources, and contact information for the Local Collaboratives.[29]

[29] For an example of an effective state resource guide, see the Maryland Community Services Locator website which links Maryland residents to 9,000 community resources: www.mdcsl.org.

INTEGRATION OF BEHAVIORAL HEALTH SERVICES WITH PRIMARY CARE

Findings:

Following the recommendations of the 2002 report *Behavioral Health Needs and Gaps in New Mexico*,[30] the Behavioral Health Collaborative was formed to oversee the administration and public funding of behavioral health services. The intended outcome was to carve behavioral health services out from other medical care. A consequence, however, has been to cut off public compensation for behavioral health services rendered in non-behavioral health sites, including primary care. At least a quarter of primary care visits involve a behavioral health or substance use issue.

There is insufficient capacity to deliver the needed services through the formal behavioral health system. Because of its numbers and geographic distribution, the further engagement of primary care in managing aspects of behavioral health and addiction medicine should be developed and encouraged beyond the services currently under the Collaborative. Many primary care providers presently provide front line clinical services for persons with addictions and other behavioral health problems, including depression and addictions.

Under the Affordable Care Act, New Mexico's ability to coordinate treatment for substance use disorders by creating "health homes" will begin in 2011, with the option to amend Medicaid plans to incorporate health homes for substance use disorders. Health homes are designed to increase collaboration among treatment providers and between treatment providers and patients. Examples of how this can be applied for substance use disorders are emerging in New Mexico.

Many older adults have chronic medical conditions for which they are receiving regular services from primary care and other specialty providers. The prevalence of problems with alcohol and other substances, as well as other behavioral health disorders, such as depression, in this population, plus the preference of most for receiving behavioral health care from primary care providers together support the rationale for behavioral health services being provided and supported in primary care settings.

Screening, brief intervention, and referral to treatment (SBIRT):
SBIRT is an established technique that can be applied in primary care and other settings to identify persons with or at risk for substance use disorders. Used along with motivational interviewing techniques and referral to treatment, this approach has been shown to

- decrease the frequency and severity of drug and alcohol use,
- reduce the risk of trauma, and

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[30] *Behavioral Health Needs and Gaps in New Mexico*, 2002.
http://www.hsd.state.nm.us/mad/pdf_files/Reports/BHGapanalysis.pdf.

- increase the percentage of patients who enter specialized substance abuse treatment.[31]

For older adults with addictions as well as other behavioral health problems, SBIRT is only one of several evidence-based practices. Most evidence-based and best practice models are collaborative models.

Recommendations for the Human Services Department, the Behavioral Health Collaborative, Medical Assistance Division, and the Health Sciences Center:

1. Set targets/goals and pathways for fully integrated primary care and behavioral health services. Primary care providers should be reimbursed when they code for visits for addiction and for common mental health problems such as depression and anxiety.

2. Strengthen educational programs for practicing clinicians and students of health care to improve assessment and treatment skills for addiction.

3. Include primary care within a continuum of care for patients as they move from one service provider to the next, and include the primary care health home setting as a location for provision of services and connection with the behavioral health clinical home and Core Service Agencies.

4. Initiate and evaluate demonstration projects for behavioral health services at primary care sites involving collaborative models of care.

5. Take steps to promote broader implementation of screening and brief intervention (SBIRT) for alcohol and other substance use problems. These steps could include the following:
    a. Enabling the use of Medicaid billing codes for SBIRT services in a variety of provider settings including primary care;
    b. Promoting broader SBIRT training for New Mexico health professionals;
    c. Taking steps to identify and recommend best practices for implementing SBIRT in privately and publicly funded primary care settings.

6. Provide education and outreach to health and social service providers to improve the recognition, assessment, and collaborative models of treatment of behavioral health problems in the elder population, particularly in substance abuse and depression and other co-occurring conditions.

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[31] Screening, brief intervention, and referral to treatment. *Co-Occurring Disorders Research and Resources Monthly Review* 2008;3(8). This review is available as pdf from http://www.samhsa.gov.

MEDICATION ASSISTED TREATMENT (MAT)

Findings:

Medication assisted treatment (MAT) with opioid replacement therapy, for example with methadone or (since 2000) buprenorphine (Suboxone and Subutex), is an established way of restoring persons with opiate addiction to stable and productive lives.

The effectiveness of MAT is abundantly documented. The risks are low. The potential for abuse, while real, is low and can be controlled. Barriers in funding and the supply of providers have limited the use of MAT.

At the same time, public funds support other adjuncts to addiction treatment that are usually less expensive but for which scientific documentation of the therapeutic value may be limited or altogether lacking. Public funding for addiction treatment should target modalities that are based on scientific evidence. In this regard, MAT with opioid replacement should be a standard of care and offered as a priority.

In general, the Behavioral Health Purchasing Collaborative pays for MAT services only when prescribed by a psychiatrist. This creates an important restriction in the availability of services that can be safely and appropriately dispensed through primary care providers in primary care settings.

Insufficient numbers of physicians are trained and certified to prescribe or dispense buprenorphine. Of those who are certified, many do not use this in practice. Numerous factors discourage participation including failure to reimburse providers who care for their patients in the context of medical care (as opposed to behavioral health care), the need obtain and then frequently renew prior authorizations, and low reimbursements for clinical services that often take extra time to address the many needs of these patients.

It can take months or longer to get an appointment for starting on treatment, even for insured patients.

Methadone replacement therapy is available in special clinics. Treatment is not covered by insure and clients are responsible for payment out of pocket. In New Mexico, the delivery of MAT services has been covered by Medicaid only with prior authorization. In contrast, at least 30 other states cover methadone through their Medicaid programs, and several have a special category of Medicaid for treatment of persons with substance abuse disorders.

Persons with histories of opiate addiction who become incarcerated are at very high risk for resumption of opiate use after release and for recidivism.[32] These risks are partially mitigated by appropriate treatment services during incarceration. Risks are further mitigated by linking the person to MAT services upon release. MAT is effective in preventing relapse and recidivism. Given prior to release, MAT may be an effective strategy. With the statewide distribution of local public health offices, the Department of Health can serve a potentially useful role in assisting with creating services to bridge linkages into community services. This has been demonstrated in Bernalillo County and Dona Ana County, and broader use should be planned.

The cost of MAT is overwhelmingly offset by the cost savings in terms of reduced medical complications of addiction, related criminal behavior, criminal justice proceedings, subsequent incarceration, and social costs and in terms of restored families and economic productivity.

MAT was addressed in detail in House Memorial 9 in a 2009 report.[33] No actions on the recommendations in this report have been taken, and the Drug Policy Task Force strongly recommends their review and reconsideration for implementation.

The currently rising number of deaths among heroin-using youths in Albuquerque and elsewhere across the state is a grim testament to the current situation. These tragic deaths stand as only one aspect of a broader situation. Persons from all walks of life are in need, often urgent, for services that are proven effective and are not receiving them. At nearly every level, our systems of care have failed. Multiple barriers stand in the way, supported by narrow policies, reluctant bureaucracies, unwilling payers of health care services, competing priorities, and other points of resistance. These must be addressed.

Recommendations regarding MAT for the Behavioral Health Collaborative and member agencies, the Medicaid Assistance Division, and the Department of Health:

1. Prioritize medication assisted treatment (MAT) in the Collaborative Comprehensive Behavioral Health Plan and the Department of Health Strategic Plan.

2. Establish a long-term goal and commitment to make medication assisted treatments such as methadone or buprenorphine as easy to access as heroin and narcotic pills.

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[32] For example, a study requested by SJM 28 from 2001 of women with a history of opiate addiction showed that 73% returned to prison within 36 months of release.

[33] *Report to Interim LHHS on House Memorial 9: Medication Assisted Treatment for Opiate Addiction.* November 4, 2009.

3. Develop an outpatient clinic connected to Turquoise Lodge where patients who have been detoxified from opiates as inpatients can be maintained on buprenorphine and continue to receive supportive and behavioral health services until they have been established for services in a primary care setting.

4. Require all Public Health Regions to establish Suboxone programs for the uninsured, based on local needs. Stable state funding will be necessary for creating and maintaining these programs.

5. Deploy existing staff in each Public Health Region to support centers of collaboration for MAT in at least one site per region.

6. Provide funding for Project ECHO at the University of New Mexico to support MAT programs and providers and to continue to train physicians for the certification needed to prescribe buprenorphine. Provide support for the Project ECHO Substance Abuse Community Health Worker program.

7. Require FQHCs and other clinics that receive state funding to ensure availability of providers for MAT and to accept patients for this service.

8. Study the current utilization of Suboxone by Medicaid-eligible clients and opportunities for expansion of use of MAT, including both Suboxone and methadone. Take steps to authorize Medicaid coverage of methadone as other states have done.

9. Work to coordinate with New Mexico Salud programs to achieve similar preauthorization processes for Suboxone in all managed care organizations and to provide a single point of entry for clients seeking services.

10. Work with Salud managed care organizations to ensure availability of primary care providers in each region who are licensed and willing to treat patients with buprenorphine.

11. Partner with the New Mexico Association of Counties to develop recommendations for the use of the model North Carolina Jail Medical Plan.

12. Plan with the Statewide Entity for behavioral health pilot or other programs to expand access to buprenorphine and methadone or develop voucher-based programs and to ensure that such expansion include primary care settings.

13. Develop incentives for clinics/programs to provide MAT in their service menus for mental health and substance abuse disorders. These may include eliminating the need for prior authorizations for buprenorphine treatment,

14. Develop substance abuse treatment standards that require publicly funded programs to train staff in medication assisted treatment and prohibit exclusion of MAT patients.

Recommendations regarding MAT for communities, health councils, and Local Collaboratives:

1. Collaborate with the University of New Mexico and the Telehealth Commission to increase telemedicine capacity throughout the state; to participate in Project ECHO; and to have direct service mental health counseling for persons in MAT.

2. Work to have addiction services, including medication assisted treatment, on priority lists for all county health councils and Local Collaboratives.

3. Support formation of local and state advocacy/activity mechanisms for addiction related matters.

4. Strengthen referral networks to/from public health or other primary care sites for target populations, as is done with tuberculosis.

5. Offer technical assistance and support to local drug courts concerning MAT. When additional funding is available, create in each Public Health Region a community care team, such as are used in Vermont, to expand and enhance the scope and scale of addiction services throughout the state.

6. Include addiction treatment and buprenorphine training and certification in training programs of all primary care specialties. Have such training available through continuing medical education on a recurring or ongoing basis.

Recommendations regarding MAT for county jails, Corrections Department, and law enforcement:

1. Work with Public Health Offices in each Public Health Region to provide buprenorphine induction for persons recently released from corrections facilities and prisons and to supply appropriate referrals to primary care providers and for continuing treatment.

2. Develop standard protocols for counseling, for referrals, and for training in the use of naloxone (Narcan) for persons released from prisons who have a history of opiate addiction before or during their incarceration, including those who have a high risk of relapse to opiate use and of overdose death after their release.

3. Develop formal discharge planning concerning substance use disorders for

all persons exiting county corrections facilities and state prisons. As resources become available, opioid addicted persons released from incarceration should be given a prescription for Suboxone and an appointment for MAT within one week of discharge.

4. Work with the county detention center affiliate of the Association of Counties to develop prerelease engagement strategies for opioid dependent inmates.

5. Encourage county detention facilities in communities where methadone maintenance programs are located (Espanola, Santa Fe, Las-Vegas) to follow the lead of Bernalillo County Metropolitan Detention Center by allowing persons enrolled in a local methadone-maintenance program to receive methadone during incarceration, either via delivery from a local clinic or through a contract with an independent contractor.

6. Provide education and training to NMCD Probation and Parole Officers to facilitate referrals of persons in community custody for MAT.

Recommendations regarding MAT for Legislature:

1. Provide tax credit or other incentive for physicians who provide buprenorphine treatment. This would be analogous to existing tax credits for physicians working in a rural setting.

2. Provide a system of payment for MAT for persons without insurance. Vouchers might be an approach.

3. Create a memorial to direct design of a comprehensive addiction treatment program, particularly for addicted teens, which would include inpatient treatment, outpatient programs that include MAT, and programs for employment, education (e.g., GED), and transitional housing.

SENTENCING AND COLLATERAL CONSEQUENCES

Findings:

In general, treatment of substance abuse in lieu of incarceration is an effective tool to divert offenders from jail beds and address the offender's struggle with substance abuse. The limited menu of community-based treatment programs, especially in rural parts of the state, is a challenge that should not deter use of this option where the capacity in the community exists. The preferred initial option would be to get the individual into an effective treatment program. This option was set forth in the 2010 legislative session in HB 178.

Regarding violations of probation, currently the rules of procedure allow a judicial district to create a Technical Violations Program. Under this program, if a probation offender provided a positive urinalysis for controlled substances, or evidence of other technical violations, he would be allowed to waive all his due process rights to contest the allegation and serve an automatic short period of incarceration (usually between 3-5 days). Currently, probationers spend weeks and sometimes months in jail awaiting a hearing on a parole violation, even when the probationer wants to admit to the allegation. The legislature should enact a bill that would require every district to create a Technical Violations Program.

About drug courts (from the New Mexico Sentencing Commission):[34]

> In 2006, the New Mexico Drug Court Advisory Committee created a five-year plan to put at least one drug court in each of New Mexico's 33 counties. New Mexico implemented 25 programs before the plan was abandoned in 2009 due to the state budget crisis. In 2010, $1 million from the state liquor excise tax funds was appropriated to the Administrative Office of the Courts to distribute among all the drug court programs statewide—an average of $40,000 per program. Two separate Lea County drug courts could not survive that budget shortfall. With the loss of the Lea County courts, there are now drug courts in 24 counties but, at this point, their futures are not assured.[35]
>
> Typically, drug offenders are placed in drug court by an order of the judge. Drug court programs provide continuous and intense judicial oversight, treatment, mandatory drug testing, immediate sanctions, and incentives. Most drug court clients are not likely to go to prison for their charges, but indirectly participation in drug court may keep the offender from being rearrested and potentially going to prison.

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[34] Cathey D, Ortiz T. *Possible Reasons for Decline in New Mexico Corrections Department Inmate Population.* New Mexico Sentencing Commission, June 2008.

[35] Abbott W. Breaking bad: drug court has helped hundreds escape from lives of drugs and crime—but does the program itself have a future? *Santa Fe Report,* January 26, 2011, "" http://www.sfreporter.com/santafe/article-5880-breaking-bad.html?current_page=6 .

A recent study found unrestricted drug treatment assistance for all at-risk arrestee offenders would prevent recidivism, promote public safety, and be cost effective.[36] Drug court goals match the findings of this study and are an excellent means for treating large numbers of at-risk individuals in a formal and systematic program.

Note: Diversion from incarceration needs to be done in the context of a treatment program with assessment and follow-up. Simply letting an offender off without consideration may invite a higher rate of recurrent offense than when the alternative is incarceration in combination with a treatment program.[37]

Recommendations for Legislature, Sentencing Commission, and Drug Courts:

1. Enact an Alternatives to Incarcerations bill that would give New Mexico judges the option of sending defendants to treatment instead of jail for drug possession, allowing judges and defendants to choose treatment in lieu of jail time on the charge of possession. If the defendant completes the treatment, the charges would be dropped. If a defendant fails to complete the treatment, the state can bring the charges again.[38]

2. Enact a bill that would require every judicial district to create a Technical Violations Program as described above.

3. Enact the Uniform Collateral Consequences Act. Under this bill, an individual charged with a crime would be informed at arraignment of collateral consequences affecting employment, education, housing, public benefits, and occupational licensing. At the time of sentencing, the individual could petition the sentencing judge for an order of limited relief from one or more of the collateral consequences. The individual could also petition the parole board at any time after sentencing for relief from a specific collateral consequence. If relief is granted, it would assist rehabilitated drug offenders to engage in gainful employment, obtain school loans, or receive other benefits necessary for successful reentry into the community.

4. Enact proposed changes to 30-31-23 (C), "Controlled substances; possession prohibited," to reduce the penalty for possession of personal use amounts of all controlled substances to a misdemeanor..

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[36] Bhati AS, Roman JK, Chalfin A. *To Treat or Not to Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders.* Washington, DC: Justice Policy Center, The Urban Institute, April 2008.

[37] Kunitz SJ, Woodall WG, Zhao H, Wheeler DR, Lillis R, Rogers E. Rearrest rates after incarceration for DWI: a comparative study in a southwestern U.S. county. *AM J Public Health* 2002;92(11):1826-1831.

[38] This was proposed in 2010 in HB 178.

5. Use drug courts when appropriate policies and procedures are in place. In order controlled substances in any amount is currently a felony. In order to ensure fairness and improve their efficacy, drug courts should:
   - Focus resources only on high-risk people facing lengthy jail terms to make certain that drug court is actually a diversion from incarceration and not more restrictive than the conventional sentence.
   - Adopt objective admission criteria and reduce the prosecutor's role as gatekeeper.
   - Use a pre-plea rather than a post-plea model.
   - Ensure due process protections and enhance the role of defense counsel.
   - Improve data collection and rigor of research.
   - Use drug tests as a treatment tool, not as punishment.
   - Limit the use of jail sanctions for drug law violations.
   - Adopt health measures—not simply abstinence—into program goals.
   - Use evidence-based practices, such as opioid maintenance treatments.
   - Ensure that practices are more health oriented than punitive.
   - Empower treatment professionals in decision-making.
   - Ensure that punishment for "failing" the program is not worse than the original penalty for the offense.

1. MANAGEMENT OF PRISONERS WITH ADDICTIONS

Findings:

Eighty-seven percent of prisoners in the Department of Corrections are estimated to have a substance use disorder.[39]

Under the consent decree following the 1980 Santa Fe prison riot and with the appointment of a Special Master to oversee all aspects of prison conditions, the Corrections Department was required to meet basic constitutional standards of incarceration, which included access to medical care meeting community standards and mental health and addictions treatment. Around 1997, under the guidance of a federally appointed expert addictions consultant, Dr. Michael Gendel, the Corrections Department developed a system of therapeutic communities (TC) to provide effective and efficient addiction services. The consent decree was fully vacated in 2002. The Addictions Services Bureau (ASB) continued to work with federal Addictions Technology Transfer Centers, universities and researchers to expand addictions treatment availability to inmates and develop and implement evidence-based treatment strategies.

Following a 2007 audit of the Corrections Department by the Legislative Finance Committee of the Corrections Department, the ASB hired Dr. Gendel to review its system of treatment services and make recommendations. His report includes the following observations:[40]

- The problems experienced by ASB are mainly systemic problems that are not solvable by the bureau.
- Therapeutic communities are a primary method of addiction treatment in many state prison systems, and studies have shown TCs to provide effective addiction treatment.
- TC effectiveness is well established in the literature and reproving it is neither necessary nor useful.
- Inmate behavior usually improves during the course of treatment, so they are often reclassified and transferred to a lower custody level facility before completing treatment.
- Recidivism can be a poor measure of treatment effectiveness, given the large number of other factors and conditions that influence recidivism, not the least of which is the glaring scarcity of aftercare resources in New Mexico.

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[39] Hand tabulation of all intake interviews at Corrections Department over a 1-year period, 2001–2002, cited in *Behavioral Health Needs and Gaps in New Mexico, the Technical Assistance Collaborative, Inc., Final Report,* July 2002, p. 64.

[40] *Report: Gendel M. Psychiatric Consultation to New Mexico Department of Corrections and Addictions Services Bureau,* June 27, 2008.

- Addictions staffing levels should at least be maintained and if possible increased.

Governor Richardson appointed a Prison Reform Task Force that issued reports in 2008 and 2009. These reports assert that the ability of the Corrections Department to successful manage prisoners with addictions is dependent on addressing the issue at a systemic level. This involves top-to-bottom acceptance as a goal and a priority that the released prisoners have a successful rehabilitation into society. It requires that the addiction be managed while in prison and that the handoff at release must appropriate and assured. It requires robust and honest evaluation.

Budget cutbacks in the Corrections Department have had a crippling effect on staffing. At the end of 2010, vacancy rate for clinical service providers in the Corrections Department was 26% overall. Outpatient services had been suspended at two facilities, and two TCs had been closed. Other services are one resignation or retirement away from disappearing.

NMCD was asked (along with other agencies) to submit a proposal to the new administration for cutting the agency budget by 10%. The NMCD proposal would entirely eliminate the Addictions Services Bureau and the Education Bureau if the budget developed in the legislative session requires the additional 10% reduction.

In approaching budget shortfalls, there may be considerations that move past cutting staff and closing down programs. To cut costs, Indiana is looking to change how it approaches the assumptions and goals behind lengthy sentencing and corrections.[41] Other states facing similar budgetary problems are looking for fresh solutions. Michigan has found savings by focusing on reentry and parole, emphasizing substance abuse treatment, job training, and job placement, which has contributed to a 15% reduction in prison population over four years. There are similar initiatives under way in New York and California.[42]

Review of evaluations of prison-based addiction treatment programs in Texas, Delaware, and California demonstrate their effectiveness in reducing re-arrest and re-incarceration and in increasing employment.[43] This particularly applies to therapeutic communities and to instances when treatment is linked with aftercare.

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[41] Indiana's answer to prison costs. New York Times, January 17, 2011. http://www.nytimes.com/2011/01/18/opinion/18tue2.html. Accessed January 19, 2011.

[42] States help ex-inmates find jobs. New York Times, January 25, 2011. http://www.nytimes.com/2011/01/25/business/25offender.html?pagewanted=1&emc=eta1. Accessed January 25, 2011.

[43] Welsh WN. *Evaluation of Prison Based Drug Treatment in Pennsylvania: A Research Collaboration Between the Pennsylvania Department of Corrections and the Center for Public Policy at Temple University, Final Report*, 2002. http://www.ncjrs.gov/pdffiles1/nij/grants/197058.pdf. Accessed December 14, 2010.

Recommendations for the Corrections Department in coordination with the Sentencing Commission, Human Services Department, and Department of Health:

1. Accept the problems within the prisons as systemic and cultural and in need of being addressed at those levels. This requires review and affirmation of priorities and policies, assurance of implementation, confirmation of action, and honest evaluation of outcomes. Restoration of addiction services to a level of standard is one component.

2. Using external addictions and correctional medicine experts in collaboration with the Department of Health and the Behavioral Health Services Division and other appropriate entities and/or consultants, the state in cooperation with the Corrections Department should conduct a review of addiction services to establish (a) process and outcome measures of programs and service effectiveness, (b) professional credentials and evidence of competence, (c) standards for assessment (screening followed by assessment and diagnosis), treatment, and follow-up, (d) range of evidenced-based and culturally appropriate treatment options, (e) systems for evaluation and reports, and (f) systems for regular external oversight. Identify areas of interface between NMCD and ASB in which the processes of treatment appear to compete with or be impeded by the processes of incarceration. Create solutions.

3. Evaluate the current re-entry preparation process and the interface between the service bureaus (addictions, education, medical and mental health), the inmates, the in-house caseworkers and Probation/Parole Division (PPD) to determine the effectiveness of the communication process and the uptake of the recommendations by PPD.

4. Evaluate processes of information sharing between Service Bureaus, in-house caseworkers, PPD and community services.

5. Lift or waive the hiring freeze to restore and expand the addictions staffing levels, in order to restore therapeutic communities, which are a proven effective intervention.

6. Have the Behavioral Health Collaborative and allies create and maintain a website to provide an effective up-to-date statewide service locator map in order to provide paroling inmates with specific community treatment recommendations upon parole.

7. Develop provisional policy to:
   a. Require the medical vendor to assure all of its physicians are certified and prepared to prescribe Suboxone.
   b. Provide Suboxone/buprenorphine MAT to inmates with a history of opiate addiction 4-8 weeks prior to parole.
   c. Provide prisoner with seamless transition to a primary care Suboxone provider and to addictions treatment in the community.
   d. Require brief training for all prison staff (wardens, correctional officers, classification and case workers, etc) and PPD staff on Suboxone and other medication-assisted treatments for addictions to enhance understanding and success.
   e. Make training and information available to parole board, sentencing commission, drug court personnel.

8. Examine potential for MAT with naltrexone for inmates with alcohol addiction, especially those with multiple DWI offenses.

9. Encourage the use of the Reentry Drug Court Program § 31-21-27. This program allows the Corrections Department to recommend an inmate for early release into a community drug treatment program if the inmate was incarcerated for a nonviolent, drug-related offense; and is within eighteen months of release or eligibility for parole. Currently, this program is not being utilized because of procedural obstacles even though the Department of Corrections has identified inmates who qualify.

10. Build a continuum of care from prison to community that is designed to engage a person and their family in a holistic and culturally appropriate manner around addiction treatment and reintegration.

1. PEER RECOVERY ACCESS DURING INCARCERATION AND AFTER RELEASE

Findings:
Persons who have been through and are in recovery from addictions are uniquely suited to provide support and mentorship for addicts. They constitute a large and underutilized resource of volunteers for this role.

The Behavioral Health Collaborative handles certification of individuals for volunteer work in the prisons and correction facilities. There is a training program for this role.

In many situations, the ability of someone incarcerated to communicate with peer counselors is limited and needs to be facilitated and encouraged.

Recommendations for Behavioral Health Collaborative, Corrections Department, Human Services Department, and counties:

Provide new and enhance existing access and reduce costs for peer support services (certified volunteers) to people who are incarcerated in prison facilities and jails and to people who are recently released as follows:

1. Simplify access to prisons by providing standardized volunteer training and a universal badge that would be recognized at every NMCD facility.

2. Focus on family support systems.

3. Increase options for volunteers to access prisoners they are mentoring:
    a. videos,
    b. dedicated telephone lines for calls to peer counselors.

4. Address similar needs at county jails.

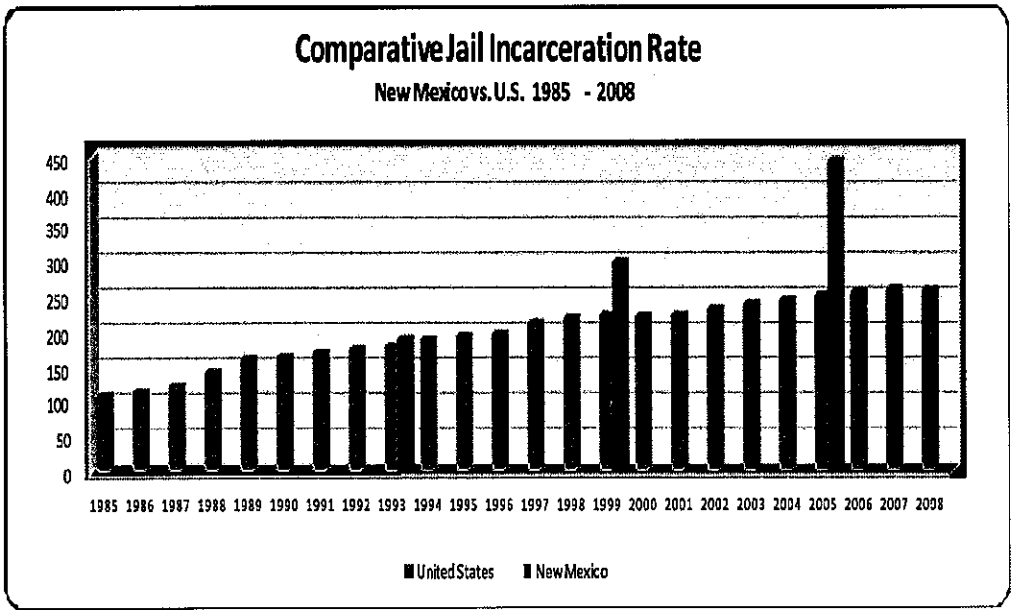
COUNTY JAILS

Findings:

Counties house the full range of criminal offender, from the violent felon to the first-time misdemeanor offender. Some of the individuals housed in county detention facilities are not charged with any crime but are brought to the county facility for protective custody due to intoxication or mental health disorders. In some jurisdictions, the jail is the community's principal option for managing behavioral health issues, including addictions.

Overcrowding in the county jails is an increasing issue. While the New Mexico Corrections Department is currently operating below its operational capacity, many county jails are overpopulated, requiring counties to rent beds in other counties or out of state. The reasons are multiple. As criminal justice resources are increasingly inadequate to manage the caseloads, arrestees spend longer and longer time in pretrial confinement. Inmates also wait for long periods to receive their judgment and sentence paperwork, delaying their transport to state facilities. There are undoubtedly other reasons as well. In addition, counties incur large, unreimbursed expenses housing parole and probation violators for the state.

The rising rate of incarceration in jails is a national issue. The rates in New Mexico are rising much faster than in most other states. The graph compares jail incarceration rates for New Mexico (red bars) with rates for the U.S. (blue bars) from 1985 to 2008.



Despite the large and growing number of individuals held in county jails, few definitive data exist regarding who is locked up, for what, and for how long. It is critical that such information be gathered in order to inform policy debates and decisions.

While there is no question that addictions play a dominating role in the number of jail incarcerations, there are in all but the largest jurisdictions (a) a lack of consistent or accurate information across the county jurisdictions and (b) the need for uniform data management systems.

Recommendations for Legislature and Sentencing Commission:

1. Make an appropriation for a survey of counties to include determination of jail census, alcohol- and other drug-related incarcerations, numbers of inmates with mental health disorders, and local resources for assessment and treatment of behavioral health and addiction problems.

2. Sentencing rules need to be examined for reducing the burdens from incarceration for minor offenses, excessive holding times, and having the jails be responsible for probation and parole violations. (See section, Sentencing and Collateral Consequences for specific recommendations.)

CONTINUATION OF THE DRUG POLICY TASK FORCE IN 2011

Findings:

The Drug Policy Task Force still has not completed some of the elements in SM 33. Additionally, the discussions need to be extended to include representatives within the new administration.

Recommendation to Senate:

Pass a memorial to continue the Drug Policy Task Force in 2011.

APPENDIX A

49th Legislature, 2nd Session, 2010
Senate Memorial 33

Introduced by Senators Bernadette M. Sanchez, Pete Campos, Linda M. Lopez, David Ulibarri, and Peter Wirth

A MEMORIAL REQUESTING THE ROBERT WOOD JOHNSON FOUNDATION TO CREATE THE DRUG POLICY TASK FORCE TO EVALUATE NEW MEXICO'S CURRENT APPROACHES TO DRUG POLICY THROUGH THE USE OF LAW ENFORCEMENT, TREATMENT, PREVENTION, AND HARM REDUCTION AND TO DEVELOP STRATEGIES FOR EFFECTIVE CHANGE.

WHEREAS, New Mexico has long been concerned about substance abuse and its impact on the people of New Mexico; and
WHEREAS, addiction is a chronic medical illness that is treatable, and drug treatment success rates exceed those of many cancer therapies; and
WHEREAS, according to a recent report issued by the federal substance abuse and mental health services administration, an estimated fifty-five thousand New Mexicans need but are not receiving treatment for an illicit drug use problem and another one hundred twenty-four thousand need treatment for alcohol abuse; and
WHEREAS, according to the Pew research center, more than one out of every one hundred Americans is incarcerated, and a recent United States department of justice report states that an estimated five hundred thousand people are incarcerated for a drug law violation nationally; and
WHEREAS, at the end of 2007, more than seven million three hundred thousand Americans, which is approximately one in every thirty-one adults, were incarcerated or on probation or parole, and roughly one-third of these were under correctional supervision for a drug law violation; and
WHEREAS, the average cost of substance abuse treatment in New Mexico is one thousand two hundred ninety-five dollars ($1,295) per person per year, and the cost of incarcerating one person in either jail or prison averages twenty-seven thousand eight hundred thirty-seven dollars ($27,837) per year; and
WHEREAS, New Mexico spent approximately twenty-two million dollars ($22,000,000) to incarcerate nonviolent drug possession offenders in 2007; and
WHEREAS, of the approximately five thousand six hundred people in New Mexico's state prison system in 2002, approximately eighty-seven percent were assessed as needing substance abuse services and seventy percent as substance abusing or dependent; and
WHEREAS, according to a study by the RAND corporation, every one dollar ($1.00) invested in substance abuse treatment results in a savings to taxpayers of more than seven dollars ($7.00) through reduced societal costs of crime, violence, and loss of productivity; and
WHEREAS, the national treatment improvement evaluation study shows substantial reductions in criminal behavior, with a sixty-four percent decrease in all arrests after treatment, making public safety a primary beneficiary of effective drug treatment programs; and
WHEREAS, federal, state, and local costs of the war on drugs exceed forty billion dollars ($40,000,000,000) annually, yet drugs are still widely available in every community, drug use and demand have not decreased, and most drug prices have fallen while purity levels have increased dramatically; and

WHEREAS, according to the office of national drug control policy, only thirty-five percent of the federal drug control budget is spent on education, prevention, and treatment combined, with the remaining sixty-five percent devoted to law enforcement efforts; and
WHEREAS, cities and states across the country have experienced a rise in violent crime and must prioritize scarce law enforcement resources; and
WHEREAS, many New Mexico teachers, prevention specialists, and school districts are using effective and science-based drug prevention strategies that focus on building resiliency and honest communication with young people about drug use; and
WHEREAS, over one-third of all HIV/AIDS cases and nearly two-thirds of all new cases of hepatitis C in the United States are linked to injection drug use with contaminated syringes, now the single largest factor in the spread of HIV/AIDS in the country; and
WHEREAS, African Americans, Latinos, and other minorities use drugs at rates comparable to Caucasians, yet non-Caucasians face disproportionate rates of arrest and incarceration for drug law violations among persons convicted of drug felonies in state courts; and
WHEREAS, according to the corrections department, one in ninety Hispanic men aged eighteen or older, one in thirty-one African American men aged eighteen or older, and one in twenty-five African American men aged twenty to thirty-four are currently incarcerated in New Mexico; and
WHEREAS, the drastic change in sentencing laws in the last quarter century has led to a seven hundred percent increase in the incarceration of women, with drug law violations accounting for one-third of the increase; and
WHEREAS, in order to promote the successful reentry into society of people leaving prison or jail, New Mexico must provide them with job training, transitional housing, family reunification services, behavioral health treatment, and the restoration of voting rights; and
WHEREAS, New Mexico continues to be a national leader in effective, public health–based drug policies, as demonstrated by its 1997 enactment of the Harm Reduction Act, which created statewide syringe exchange programs, and the department of health's 2001 overdose prevention and response initiative; and
WHEREAS, the use of a four pillar approach to drug policy, incorporating law enforcement, treatment, prevention, and harm reduction, can save both lives and money in New Mexico;
NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the Robert Wood Johnson foundation center for health policy be requested to create a drug policy task force to evaluate New Mexico's approach to alleviating the negative consequences associated with the use of alcohol and other drugs; and
BE IT FURTHER RESOLVED that the drug policy task force utilize a four pillar approach to examine prevention, treatment, harm reduction, and enforcement and develop strategies for effective change in New Mexico's drug policy; and
BE IT FURTHER RESOLVED that the drug policy task force include representation from the office of the governor, the office of the lieutenant governor, the corrections department, the department of health, the children, youth, and families department, the human services department, the public education department, designees appointed by the New Mexico legislative council, the legislative finance committee, the DWI grant council, the aging and long-term services department, county detention facilities, the administrative office of the courts, the department of public safety, the interagency behavioral health purchasing collaborative, the behavioral health planning council, the university of New Mexico, the New Mexico association of counties, the drug policy alliance, the New Mexico women's justice project, two individuals with criminal drug convictions, and two individuals in recovery from substance abuse; and
BE IT FURTHER RESOLVED that the drug policy task force be chaired by a representative from the Robert Wood Johnson foundation center for health policy and that it meet at the call of the chair at least three times before October 15, 2010; and

BE IT FURTHER RESOLVED that the drug policy task force write a comprehensive statewide strategic plan based on the four pillar approach and report and present its findings to the interim legislative health and human services committee, the interim legislative courts, corrections and justice committee, and the legislative finance committee by November 2010; and

BE IT FURTHER RESOLVED that the strategic plan include a section on current approaches to drug policy, including the number and geography of people impacted, local and statewide assessments of services and needs, a detailed list of expenditures in prevention, treatment, harm reduction, and enforcement, and an assessment of the effectiveness of the current programs; a section on prevention recommendations; and a section on treatment recommendations; and

BE IT FURTHER RESOLVED that the task force develop a list of evaluation measures to include the impact of drug abuse on youth, rates of drug overdose fatalities, rates of HIV/AIDS and hepatitis, access to treatment, the number of incarcerated nonviolent drug law offenders, access to alternatives to incarceration, and racial disparities exacerbated by the criminal justice system; and

BE IT FURTHER RESOLVED that the strategic plan place special emphasis on the sections on prevention and treatment and establish short- and long-term recommendations to reduce the impact of drug use and drug policies on the people of New Mexico by utilizing cost-effective initiatives; and

BE IT FURTHER RESOLVED that the written report include objectives to address drug overdose fatalities, HIV/AIDS and hepatitis, access to treatment, the number of incarcerated nonviolent drug law offenders, alternatives to incarceration, and racial disparities exacerbated by the criminal justice system; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the director of the Robert Wood Johnson foundation center for health policy and to each of the agencies or organizations named to participate in the task force.

APPENDIX B

Drug Policy Task Force Members, Consultants, Advisors, and Participants:

Steven Adelsheim	UNM Center for Rural and Community Behavioral Health
Judy Arciniaco	OptumHealth
Bette Betts	ALTSD
Susan Bosarge	BHSD
Lisa Broidy	UNM Institute of Social Research
Pam Brown	NMDC
Curtis Cherry	Sierra County Detention
Jane Davis	BHSD
Claire Dudley	Lt. Governor's Office
Eric Eichler	Drug Policy Alliance intern
Mike Estrada	NMDC
Riesha Fiorina	Drug Policy Alliance intern
Brandi Jimenez	Grant County
Kristin Jones	CYFD
Harrison Kinney	BHSD
Francine Hatch	Indian Affairs
Brendon Houston	State Police
Val Hubbard	Drug Policy Alliance
Amber Leichtle	Rio Arriba County
Sheila Lewis	Drug Policy Alliance NM Women's Justice Project
Bernie Lieving	Independent/Albuquerque
Felice Marohn	Drug Policy Alliance Intern
Karen Meador	BHSD
Robert Medina	Independent/Zia
Tony Ortiz	NM Sentencing Commission
Grace Philips	NM Association of Counties
Lauren Reichelt	Rio Arriba County
Jim Roeber	DOH/ERD
Linda Roebuck	Behavioral Health Collaborative
Tony Sanford	CYFD
David Schmidt	Juvenile Justice Advisory Committee
Nina Shah	DOH/ERD
Herman Silva	DPS
Jana Spalding	OptumHealth
Mary Stoeker	DOH/Grant County
Jaye Swoboda	Physician/Questa
Bruce Trigg	DOH
Suzie Trujillo	Grant County

Estela Vasquez-Guzman	RWJF Center at UNM graduate fellow
Jennifer Weiss	Heroin Awareness
Chris Wendel	BH Planning Council
Glenn Wieringa	DOT/BB
Bill Wiese	Task Force convener, RWJF Center at UNM
Dominick Zurlo	DOH/IDB

APPENDIX C

2010 Locations and Meeting Dates of the Drug Policy Task Force

Albuquerque, June 7
Santa Fe, July 12
Santa Fe, August 16
Santa Fe, September 7
Santa Fe, October 19
Santa Fe, November 9
Santa Fe, December 13

Agendas and minutes of the meetings are posted on the website of the RWJF Center for Health Policy at the University of New Mexico: http://healthpolicy.unm.edu/about/Initiatives/SM33.

APPENDIX D

National Institute on Drug Abuse (NIDA)
Principles of Drug Abuse Treatment for Criminal Justice Populations[44]

Drug addiction is a brain disease that affects behavior.
Drug addiction has well-recognized cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs, despite the harmful consequences. Scientists have also found that chronic drug abuse alters the brain's anatomy and chemistry and that these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicts are at a high risk of relapse to drug abuse even after long periods of abstinence and why they persist in seeking drugs despite deleterious consequences.

Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence over time. Multiple episodes of treatment may be required. Outcomes for drug abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

Treatment must last long enough to produce stable behavioral changes.
In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior. Individuals with severe drug problems and co-occurring disorders typically need longer treatment (e.g., a minimum of three months) and more comprehensive services. Early in treatment, the drug abuser begins a therapeutic process of change. In later stages, he or she addresses other problems related to drug abuse and learns how to manage the problem.

Assessment is the first step in treatment.
A history of drug or alcohol use may suggest the need to conduct a comprehensive assessment to determine the nature and extent of an individual's drug problems; establish whether problems exist in other areas that may affect recovery; and enable the formulation of an appropriate treatment plan. Personality disorders and other mental health problems are prevalent in offender populations; therefore, comprehensive assessments should include mental health evaluations with treatment planning for these problems.

Tailoring services to fit the needs of the individual is an important part of

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[44] National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide.* NIH Publication No. 06-5316, July 2006.

effective drug abuse treatment for criminal justice populations.
Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of supervision needed. Individuals also respond differently to different treatment approaches and treatment providers. In general, drug treatment should address issues of motivation, problem solving, skill building for resisting drug-use-related criminal behavior, the replacement of drug using and criminal activities with constructive non-drug-using activities, improved problem solving, and lessons for understanding the consequences of one's behavior. Treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

Drug use during treatment should be carefully monitored.
Individuals trying to recover from drug addiction may experience a relapse, or return, to drug use. Triggers for drug relapse are varied; common ones include mental stress and associations with peers and social situations linked to drug use. An undetected relapse can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention. Monitoring drug use through urinalysis or other objective methods, as part of treatment or of criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities for intervention to change unconstructive behavior-determining rewards and sanctions in order to facilitate change and to modify treatment plans according to progress.

Treatment should target factors that are associated with criminal behavior.
"Criminal thinking" is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior. These can include feeling entitled to have things one's own way; feeling that one's criminal behavior is justified; failing to be responsible for one's actions; and consistently failing to anticipate or appreciate the consequences of one's behavior. This pattern of thinking often contributes to drug use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes.

Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.
The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals. Treatment providers should collaborate with criminal justice staff to evaluate each individual's treatment plan and ensure that it meets correctional supervision requirements as well as that person's changing needs, which may include housing and childcare; medical, psychiatric, and social support services; and vocational and employment assistance. For offenders with drug abuse problems, planning should incorporate the transition to community-based treatment and links to appropriate postrelease services to

improve the success of drug treatment and reentry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication, to prevent relapse. Ongoing coordination between treatment providers and courts or parole and probation officers is important in addressing the complex needs of these reentering individuals.

Continuity of care is essential for drug abusers reentering the community.
Those who complete prison-based treatment and continue with treatment in the community have the best outcomes. Continuing drug abuse treatment helps the recently released offender deal with problems that become relevant only at reentry, such as learning to handle situations that could lead to relapse; learning how to live drug free in the community; and developing a drug free peer support network. Treatment in prison or jail can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior postincarceration. Continuing drug treatment in the community is essential to sustaining these gains.

A balance of rewards and sanctions encourages prosocial behavior and treatment participation.
When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers" such as recognition for progress or sincere effort can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used early and for less serious noncompliance, with increasingly severe sanctions issuing from continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior.

Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.
High rates of mental health problems are found both in offender populations and in those with substance abuse problems. Drug abuse treatment can sometimes address depression, anxiety, and other mental health problems. Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt drug treatment. The presence of co-occurring disorders may require an integrated approach that combines drug abuse treatment with psychiatric treatment, including the use of medication. Individuals with either a substance abuse or mental health problem should be assessed for the presence of the other.

Medications are an important part of treatment for many drug abusing offenders.
Medicines such as methadone and buprenorphine for heroin addiction have been shown to help normalize brain function and should be made available to individuals who could benefit from them. Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in society. Behavioral strategies can increase adherence to medication

regimens.

Treatment planning for drug abusing offenders who are living in or reentering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis. The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS, are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with federal and state laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on how to modify risk behaviors. Probation and parole officers who monitor offenders with serious medical conditions should link them with appropriate health care services, encourage compliance with medical treatment, and reestablish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail.

APPENDIX E

New Mexico Corrections Department Census and Treatment Capacity

The New Mexico Corrections Department (NMCD) maintains data on each inmate's offense(s) but does not collect information regarding the circumstances, motivation or context of the crime. Therefore, the number of direct drug and alcohol crimes (possession, trafficking, manufacturing, DWI, vehicular homicide under the influence, etc) can be identified, but the number of drug-related crimes (e.g. crimes committed because of drug use or to get money to obtain drugs) is not known.

On January 11, 2011, 2,610 of 6,637 inmates were serving sentences for direct drug and/or alcohol crimes in NMCD (Table1).

Table 1. NMCD Inmates with Direct Drug and/or Alcohol Crimes by Gender
Jan. 11, 2011

	NMCD population 1/24/11	No. inmates with drug crimes	% inmates with drug crimes	No. inmates with alcohol crimes	% Inmates with alcohol crimes	No. non-duplicated inmates with drug and/or alcohol crimes	% non-duplicated inmates with drug and/or alcohol crimes
Female	595	285	47.9%	47	7.9%	322	54.1%
Male	6042	1858	30.8%	515	8.9%	2288	37.9%
Total	6637	2143	32.3%	562	8.5%	2610	39.3%

The annual cost to NM Corrections Department for prisoners with direct drug and alcohol crimes is estimated to be $107,000,000. This is based on the FY09 calculation of $41,000 per year per inmate. It does not include prisoners with indirect drug crimes (e.g. forgery, burglary, auto theft, etc.)

The NMCD Addictions Services Bureau (ASB) operates 11 therapeutic communities (TCs) with a combined capacity 768 beds (11.6% of all NMCD beds). ASB also has an outpatient (OP) treatment capacity of 350 slots (about 700 per year). ASB recruits and encourages AA and NA volunteers to bring provide support groups in prison and are available at most prisons.

Participation in treatment contributes to prison safety and security. There are significantly fewer major and minor disciplinary infractions among TC inmates compared to non-TC inmates (major: TC 0.2% vs. non TC 10.8%; minor: TC 0.63% vs. non-TC 14.1%), and there are significantly fewer positive drug screens among TC participants compared to non-TC participants.

If approximately 5,650 (85%) current inmates have an Substance use disorder, the treatment capacity of 1,468 per year the currents services covers about 26% of the population needing addictions treatment (Table 2). The clinical staffing ratio for

inmates with substance use disorder-is 1:113. The clinical staffing for inmates in treatment is 1:29.

Table 2. Addictions Service Bureau (ASB) Clinical Provider FTEs and Vacancies, and Inmate Population as of 1/24/2011

	Actual inmate population*	TC treatment beds	OP treatment beds	Allotted FTEs total	FTEs filled	FTEs vacancy	% ASB staff vacancy
PNM	847	0	55	5	3	2	40%
CNMCF*	836*	66	0	4	3	1	25%
RCC	330	100	0	4	2	2	50%
SNMCF	698	52	55	5	3	2	40%
WNMCF	418	0	40	2	1	1	50%
SCC	277	58	75	3	3	0	0
Total for state facilities	3406	276	225	23	15	8	35%
LCCF	1094	298	30	16	11	5	31%
GCCF	555	58	25	3	3	0	0
NENMDF	627	56	50	4	4	0	0
NMWCF	595	80	20	4	2	2	50%
Totals for private facilities	2871	492	125	48	35	13	27%
Total state and private	6277	768	200	71	50	21	30%

*Does not include 360 intake beds.

Abbreviations:

TC	therapeutic community
OP	outpatient
PNM	Penitentiary of New Mexico
CNMCF	Central New Mexico Correctional Facility
RCC	Roswell Correctional Center
SNMCF	Southern New Mexico Correctional Facility
SCC	Springer Correctional Center
LCCF	Lea County Correctional Facility
GCCF	Guadalupe County Correctional Facility
NENMDF	North East New Mexico Detention Facility
NMWCF	New Mexico Women's Corrections Facility

This report was assembled at the
Robert Wood Johnson Foundation Center for Health Policy
at the University of New Mexico
from drafts submitted by Drug Policy Task Force members.

Recommendations are based on consensus developed at Task Force meetings.

The views expressed in this document are those of the Taskforce and do not necessarily represent the RWJF Center for Health Policy, the University of New Mexico, or collaborating organizations or funders.

Editing was done by
William H. Wiese, chair of the Drug Policy Task Force.

Minutes of the meeting are available at
http://healthpolicy.unm.edu/about/Initiatives/SM33.

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